State of Michigan Employees - New Hires **4/1/2010**

SUMMARY OF BENEFITS AND COVERAGE	
PHYSICIAN SERVICES / PREVENTATIVE SERVICES	
Primary care office visits	$20 Co-pay
Specialist office visits	$20 Co-pay
Annual physical exam	$20 Co-pay
Annual well woman visit	$20 Co-pay
Hearing and vision screening	$20 Co-pay
Immunizations (pediatric)	$20 Co-pay
PSA screening	$20 Co-pay
Well child care	$20 Co-pay
Allergy test, treatments, and injections	$20 Co-pay
Chiropractic care (20 visits per year)	$20 Co-pay
Nutritional counseling and education	$20 Co-pay
Health education and counseling	$20 Co-pay
MATERNITY SERVICE	
Prenatal & postnatal care	$20 Co-pay (one time Co-pay)
Delivery in hospital	Covered
Well baby care in hospital	Covered
INPATIENT HOSPITAL SERVICES	
Unlimited days in a semi-private room; surgery, all physicians and other ancillary services; related drug therapy; lab tests and x-rays	Covered
OUTPATIENT PROCEDURES	
Surgery and all invasive procedures conducted in any outpatient setting, including physicians and other ancillary services; related drug therapy; lab tests and xrays	Covered
EMERGENCY MEDICAL SERVICES	
Physician and hospital emergency room services (Co-pay waived if admitted)	$200 Co-pay
Ambulance services (when medically necessary)	Covered
AFTER HOURS MEDICAL SERVICES	
Participating after-hours care centers (Urgent Care)	Covered
DIAGNOSTIC & THERAPEUTIC SERVICES	
Outpatient lab tests; diagnostic x-rays; and radiation therapy at a hospital	Covered
Chemotherapy	Covered
Physical, occupational and speech therapy	Covered
Non-preventative diagnostics including lab, x-ray, pathology, and special diagnostics in a non-hospital setting	Covered
Mammograms	Covered
MENTAL HEALTH CARE	
Outpatient treatment	Covered
Inpatient psychiatric hospital services	Covered
SUBSTANCE ABUSE TREATMENT	
Outpatient Care	Covered
Intermediate Care	Covered
OTHER SERVICES	
Home Health Care (limited to 100 visits/year)	Covered
Hospice care	Covered
Skilled Nursing Care Facility (limited to 120 days per calendar year)	Covered
DURABLE MEDICAL EQUIPMENT / PROSTHETIC DEVICES	
Covered when medically necessary	Covered
HEARING SERVICES	
Hearing exam and hearing aid testing	Covered
Hearing aid (limited to one every three years)	Covered
VISION SERVICES	
Eye exam (limited to one year)	Covered
Eyeglasses (limited to one pair every two years)	Covered
PRESCRIPTION DRUG SERVICES	
Formulary medications prescribed by a THC participating provider and through a THC participating pharmacy *When no Generic equivalent is available	$10 Generic / $30 Brand Formulary $60 Brand Non-Formulary

The benefits described above are intended to be only a summary description. For details, please review the Certificate of Coverage Agreement.